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ABSTRACT

Data on the progress of the woman M.D. from admission to medical school and through practice are presented in summaries of four papers on the topic. In "Women in Academic Medicine," Judith Braslow argues that the medical school interview is particularly difficult for women and that there is a need for greater representation of women on medical school faculties. Elizabeth McAnarney's paper on "Women in the Medical Schools in the Last Decade" focuses on the dilemma of women houseofficers, contending that this group has the highest risk of developing major problems that have been inadequately addressed. In "Affirmative Deception: The Case of Women Physicians and the Computer Matching Plan for Interns and Residents," by Mary Roth Walsh, it is argued that as of 1977 the equal admissions policy had not ended the extremely negative attitude toward women applicants. The attitudes that still inhibit the performance of women physicians are examined. In "Persisting and Nonpersisting Women M.D.'s: Personality Variables Explored," Dorothy Rosenthal Mandelbaum argues that variations in practice patterns may be due to differences in personality. It is concluded that women physicians are either women focused on self-actualization through career, or women who often choose to marry and rear children as well as to work. (Author/PHR)

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SIXTEENTH ANNUAL CONFERENCE

ON

RESEARCH IN MEDICAL EDUCATION

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Washington, D. C.

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November 9-10, 1977

SYMPOSIUM

THE WOMAN PHYSICIAN: RECENT RESEARCH PERSPECTIVES

Organizer: Dorothy Rosenthal Mandelbaum, Ph.D.

Participants: Judith B. Braslow
Elizabeth McAnarney, M.D.
Mary Roth Walsh, Ph.D.
Dorothy Rosenthal Mandelbaum, Ph.D.

Objective:

As increasing numbers of women have entered the medical profession in recent years, the purpose of this symposium is to share recent data on the progress of the woman M.D. from admission to medical school through practice. Implications for the medical profession are suggested.

THE WOMAN PHYSICIAN: RECENT RESEARCH PERSPECTIVES

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As increasing numbers of women have entered the medical profession in recent years, the purpose of this proposed symposium is to share recent data on the progress of the woman M.D. from admission to medical school through practice. Implications for the medical profession are suggested within each of the four papers whose summaries follow.

Judith Braslow argues that the medical school interview is particularly difficult for women and that there is a need for greater representation of women on medical school faculties. Her paper presents "The latest available data from the AAMC" and makes "some recommendations as to what steps institutions might take in making the environment more conducive for women both studying and working in an academic medical center."

Elizabeth McAnarney, who examined medical schools to determine whether any changes have occurred for women medical students, houseofficers and faculty for the Josiah Macy Foundation, will focus on the dilemma of women houseofficers. It is McAnarney's contention that this group has "the highest risk of developing major problems which have been inadequately addressed."

Mary Roth Walsh's paper focuses upon the computer matching plan for interns and residents. She argues that as of 1977 "'equal admissions' had not ended the extremely negative attitude toward women applicants, nor had it provided an atmosphere where women, once accepted, could expect equal treatment." Her paper will examine those attitudes which "are still inhibiting the performance of women physicians."

Dorothy Rosenthal Mandelbaum will argue that variations in career persistence in practice patterns may be due to differences in personality. She found 40 Persisters to differ significantly from 31 Nonpersisters on half the variables measured by Gough's ACL. It is her conclusion that because of only slight variation between groups in practice patterns, that the profession accept "the committed woman physician as having two...alternate forms."

Women in Academic Medicine

by
Judith B. Braslow
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President for
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The issues related to women in academic medicine particularly concern admission of women to medical school and participation of women on U.S. medical school faculties. This paper will address those two issues by presenting the latest available data from the Association of American Medical Colleges and then making some recommendations as to what steps institutions might take in making the environment more conducive for women both studying and working in an academic medical center.

Admission of Women to Medical School

In a movement that could affect both the teaching and practice of medicine, women are entering medical schools and ultimately practicing medicine in dramatically increasing numbers. Since the academic year 1972-73 the increase in women in the first year class has risen from 2300 to 3858 for 1976-77 --- an increase of almost 68% at a time when total first year enrollments increased by about 1900. During that same period of time the total enrollment increase for women has been about 7000, an increase of about 100%. Moreover, that increase is continuing. Last fall 24.7% of the first year class were women where as in the fall of 1975-76 23.6% were women. That increase is occurring at a time when the number of women applicants is rising, yet the overall number of applicants is decreasing. Further increases are expected next fall.

The influx of women has produced a number of changes and adjustments which are worthy of note. One of the most significant of these is in the interview, which for many applicants who are invited for an interview is the most difficult part of the entire admissions process. It is particularly difficult for women because personal qualities are being assessed for a profession whose doors have only recently been open to increased numbers of women. In addition, it places women in a situation where the issues, both real and imaginary, of attrition and inactivity on the one hand and physicians shortages and costs to educate on the other, converge and thus make their candidacy for admission by definition different from men.

Once all the data is in and the interviews are completed, the very difficult task of actual selection begins. At this point admissions committes must begin to select the criteria upon which they will make their decisions. One variable which seems to have some effect at this stage of the process is age. As the data will indicate there is a higher proportion of both men and women chosen from among the younger applicants with the largest numbers of accepted applicants coming from the 21-23 age group. Additionally, the number of older applicants is increasing nationally. Particularly for women, medical school was not a particularly viable option when they were younger.

The common explanation for giving preference to the younger applicant is because he or she has many more years of potential practice than the older applicant. This emphasis on the younger student generally works to the disadvantage of women students who are often older and returning to school after brief careers in other fields and/or as mothers and wives. On the other hand, the data would indicate that admissions committees have made some allowances for women since a greater percentage of women are accepted in the 24-37 age range than are men.

Women Faculty in U.S. Medical Schools

The data on women faculty both nationally and among specific institutions is enlightening because it clearly reveals that despite the increase of women students in medical schools, the change in female participation on U.S. faculties has been minimal. Nonetheless, there are some observations about women faculty worth noting. They are:

- Women faculty serve on most admissions committees.
- Salaries, promotions, and tenure are gradually becoming more equitable for women faculty.
- Few women hold administrative positions in U.S. medical schools.
- Women physicians have never served as presidents of mainstream national specialty associations.
- There is still a dearth of excellent faculty female role models for female students.

The responsibility for attracting more women to the field of medicine and then ultimately into academic medicine must be jointly shared by both the institutions and women practitioners. Some suggested action steps for institutions and individuals will be discussed.

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Women in the Medical Schools in the Last Decade

This paper will focus on a study supported by the Josiah Macy, Jr. Foundation in 1976. The focus of the study was to determine if there had been any changes for woman in the medical schools at the levels of medical student, houseofficer, and faculty. Time will not permit a complete presentation of the data, but the primary focus will be on the dilemma of women houseofficers.

As a part of the study between March and June; 1976, eleven academic medical centers (approximately 9% of the nation's 116 medical schools) were site-visited. The selection of sites to be visited was based on the total number of students; the percentage of women entering the first year class of 1974, the geographical location; and institutional status. Medical centers representative of both large and small student bodies, high and low percentages of women, divergent geographic regions in the country, and private and public institutions were chosen. All institutions contacted agreed to site visit. In all, there were 35 administrative, 154 medical student, 105 faculty, and 55 housestaff contacts. Individuals were interviewed using standard protocols initially piloted at the University of Rochester.

Major findings were as follows. There were nearly four times as many women medical students enrolled in the nation's medical school in 1974-1975 as there were in 1964-1965 and nearly five times as many in 1975-1976 as in 1965-1966. Admissions committees in those medical centers visited were uniformly interested in admitting the best students, regardless of sex. Medical students corroborated equity in admissions procedures. Most women medical students had experienced fair admission interviews. For those who did not, the consensus of opinion was that it represented an individual interviewer's bias against women rather than the school's. Male students were supportive of their female collegaues and often debated issues regarding women's rights with the women. Faculty were supportive and motivated to train female students. There were a variety of supportive services such as group counselling for women being developed in several settings. Some female students felt there were still evidence of discrimination against them as women by individual faculty and colleagues. There were few flexible medical school programs that accommodated the individuals unique needs. In general, most women felt that medical school was a positive experience.

Notable among the changes for women faculty in the last decade were the representation of women on admissions committees in most medical schools, growing equity in salaries and promotions and tenure, and greater options for individual women faculty by virtue of approved mobility between medical schools. There was a dearth of excellent faculty female role models for female students, few faculty women

held administrative offices, and women still tended to populate several specialty areas such as Pediatrics, Anesthesiology, Physical Medicine, and Public Health-Preventative Medicine.

The group of women for whom there were the least data and the most concern was the houseofficers. Many of todays houseofficers tend to have postive, supportive experiences in the nation's schools as students. Increasing numbers are entering specialties that traditionally have not been open to women such as surgery and the surgical subspecialties, some internal medicine programs, and obstetrics-gynecology. Male colleagues in these areas may not be convinced of the efficacy of training women in their specialties. The woman houseofficer may find that she is virtually alone and in a nonsupportive atmosphere as she pursues her post-graduate education. Additionally, women at the houseofficer level frequently were making major decisions about their families and careers and lacked the requisite time and energies to address these issues in a meaningful way. Female houseofficers represented the group who was at the highest risk of developing major problems which have been inadequately addressed.

In general, women and men were optimistic about the future of women in medicine.

"Affirmative Deception: The Case of Women Physicians and
The Computer Matching Plan for Interns and Residents

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This study analyzes the socio-pyschological forces inhibiting progress for women physicians as they move from the medical school and begin their medical careers, first as interns and then as residents. The paper is based on a detailed investigation of one hospital in the Northeast whcih demonstrates the difficulties involved in changing access opportunitites for women in the medical profession. The methodology involved interviews, surveys, meetings, letters and other documents as well as participant observation between 1971 and 1977, the period when expanded numbers of women medical students began applying for internship positions.

Over a quarter of a century ago, in 1950, the National Intern Matching Program was established. In 1968 it was expanded to include resident matching and became the National Intern and Resident Matching Program. That year 97 percent of the U.S. medical school graduates participated in the program. A medical student voluntarily registers with the program and makes applications to the hopsitals of his or her choice. The applicant's choice of the hospitals, ranked in order of preference, is then sent to the program. Each hospital, in turn, ranks its applicants and files the information with the program. During one weekend each spring, the two lists are matched by a computer.

During the period 1972 to 1975 the number of unmatched candidates increased from 5 to 20 percent of the total. Also, in the same time period, the number of U.S. medical students who do not take part in the internship matching program has doubled from 8 to 16 percent. Various explanations have been made for the changes in program patterns and these have, for the most part, depended on macroscopic studies of such global characteristics as numbers of positions listed, numbers of unmatched candidates, and the location of medical schools.

What has been ignored is the impact of escalating numbers of women medical school graduates on the internship and resident matching program at the level preceeding computer processing. This study analyzes the psychological and social forces at work in one hospital as intern selection committees continued to discriminate against qualified women candidates in the early 1970's. At this point, a female physician at the hospital gathered data from other hospitals in the same geographical area which showed higher rates of female admissions and she presented these statistics to the department chair. As a result, he conceded to a plan whereby candidates would be discussed almost solely on merit with very little mention being made of their sex.

Less than two years after this plan has been initiated, a second wave of resistance set in. There were 30 percent women applicants, but only 20 percent of the top 40 applicants ranked for the matching plan were women so that only 4 females on it had any chance whatsoever for an internship. For two of these candidates, information had been obtained in the interview of the applicant to confirm the fact that these women were unlikely to rank the hospital very high and they would probably choose an internship elsewhere. All other female candidates were placed at the bottom of the list entirely beyond the reach of the intership.

At this point, this same female physician asked openly for the support of other physicians in the department and she decided to do whatever was ncessary, including legal action, to guarantee fairness in the selection process. The events that followed this illustrate the long and painful process of forcing change in such circumstances. In the end, legal measures were not used because the department chair agreed to a new selection procedure of two men and women who would do the final selection process. The chair would only serve as advisor and would have no vote except in the case of a tie.

The end result of these steps was the development of a national set of criteria which was clearly and carefully defined, based on evidence, and though only 3 women of 10 interns were selected in 1975, the women were confident that a new era had been introduced and the previous discriminatory patterns had come to a close.

In the Spring of 1977, however, it became clear that "equal admissions" had not ended the extremely negative attitudes toward women applicants, nor had it provided an atmosphere where women, once accepted, could expect equal treatment. One observer described the hospital as "an armed camp" after news filtered down that 9 of the 11 incoming interns in department were to be female.

This paper will describe in detail the attitudinal forces which are still inhibiting the performance of women physicians. These attitudes are revealed in interviews with women physicians at the hospital, in comments and letters of male physicians, in behavioral patterns of the men and women physicians who are eligible to serve on admissions committees, and the responses of the women interns who enter hospitals under such circumstances. The circumstances in this hospital are then briefly compared to other hospitals where similar patterns of sex discrimination exist to handicap women interns. It concludes by suggesting that what is involved is a systemic response to women as a group and points to the long road ahead before we can insure that sex discrimination does not handicap qualified women applicants in their careers.

PERSISTING AND NONPERSISTING WOMEN MD'S: PERSONALITY VARIABLES EXPLORED

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Purpose

The purpose of this study was to explore 146 selected psychological and situational factors which might differentiate women physicians who practice from those who withdraw. It was assumed that underlying the decision to persist or withdraw (except in those instances in which advanced age or ill health predominate), are well-imbedded personality dispositions which are directly related to feminine self-definition. These emerge as decisive factors at times of conflict and are critical determinants of ultimate resolutions. The major groupings of variables, examined for differences between Persister and Nonpersister, included: 1. Imbedding of the career goal. 2. Personality differences. 3. Marital status. 4. Maternal status. 5. Women physicians as marginal persons. 6. Differences in role priorities. 7. Differences in work behaviors and attitude. 8. Self-esteem. The present paper will review the differences in personality between groups as measured by Gough's ACL.

Procedures

In order to test the stated assumptions and their derived hypotheses 71 randomly-selected women physicians in the Philadelphia metropolitan area participated in the study during 1973. Basic demographic information was gathered by means of mailed questionnaires prior to the administration of in-depth interviews and the Gough Adjective Check List.

On the basis of the data collected the 40 Persisters and 31 Nonpersisters were defined as followed:

Persisters

1. Those who have always worked. 2. Those retired at the time of the study for reasons of age or disability but who had, prior to retirement, not worked for cumulative periods of less than one year. 3. Those working at the time of the study who had at some time not worked for a cumulative period of time of less than one year.

Nonpersisters

1. Those not working for reasons other than age or disability. 2. Those working at the time of the study who have had cumulative non-work periods of one year or longer.

Results and Conclusions

Despite their basically similar patterns of professional socialization until at least their mid-twenties, Persister and Nonpersister women physicians were found significantly different on 45 variables at the .05 level or less. The results indicate clear differences on 12 of 23 personality variables of the ACL.

The data clearly suggest that career persistence and personality are related. The modal P was found more in control of, and more accepting of, the self. The modal NP, on the other hand, was found both more individualistic and more troubled.

These personality differences may explain the observed differences in adult role preferences: the modal P more often adopted a conventional single career track whereas the modal NP more often chose the more challenging dual or triple track, including marriage and motherhood. It may be that very preference which tilts the NP scale in favor of withdrawal for reasons of inner conflict and strain.

What is as yet unclear is the sequence of events. Is the NP unhappy because of her internal conflict as the result of her withdrawal, or was she troubled by doubts prior to her career commitment? Is the P only now experiencing the need to nurture and to affiliate with others because of previous neglect of these areas or had they existed earlier as well? What is quite clear, however, even from this limited sample, is that P and NP women MD's evidence distinct personality profiles.

Implications

In considering P and NP in this study, we are not considering either-or alternatives in which participants either worked or did not. Rather, we have examined a situation in which some women, for reasons that stem from within, are at some times in their lives removed from their careers for family reasons for even brief periods of time.

The primary implication stemming from this research, therefore, is that we view the committed woman physician as having two, rather than one, alternate forms. On the one hand there exists the recognized highly-driven, career-channeled woman who focuses upon self-actualization through career. On the other, however, is found that individualistic woman MD who, for reasons of self, more often chooses to marry and rear children as well as to work. The challenge confronting her, those significant to her and members of the medical profession is: To what extent may she be accepted for herself as a woman and as a physician? The degree to which she is accepted in her totality as a person may, in fact, determine the success of her ability to withdraw temporarily and ultimately to return to her medical career.